ORIGINAL COMMUNICATIONS

RECOGNIZING THE INCESTUOUS FAMILY

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Family physicians are in the best position to diagnose incest because of the nature of their practice. Yet many cases of incest are not recognized by the medical community and many incest victims are thus untreated. There are several behavioral and medical clues to incest, which the family physician needs to know in order to recognize incest early and improve the prognosis. Treatment is directed at the whole family, rather than just the active participants. Further research is needed to improve the application of various treatment modalities.

Among health care personnel, the family physician is in a unique position to detect incest. Unlike other specialists, the generalistic practice of the family physician allows contact in pediatrics, gynecology, psychiatry, and emergency care. This gives him or her more opportunities to observe a variety of different signs of incest. Secondly, since longitudinal care is often provided to multiple members of the same family, behavioral and health problems that are present in incestuous or incest-prone families are more likely to become evident. However, these advantages cannot be fully utilized if the physician is not aware of the factors that indicate an incestuous family. The clinical data important for the recognition of the incestuous family will be reviewed and a methodology for the collection of these data will be presented.

Presented to the 87th Annual Convention and Scientific Assembly of the National Medical Association, San Francisco, California, July 25-29, 1982. Requests for reprints should be addressed to Dr. Mark S. Johnson, Robert Wood Johnson Clinical Scholar Program, School of Medicine 207H, University of North Carolina, Chapel Hill, NC 27514.

EPIDEMIOLOGY

The National Center on Child Abuse and Neglect uses the term "intrafamily sexual abuse" for incest, and defines it as abuse "which is perpetrated on a child by a member of that child's family group" and "includes not only sexual intercourse, but also any act designed to stimulate a child sexually, or to use a child for the sexual stimulation, either of the perpetrator or of another person."[1] Figures estimating the frequency of incest vary widely. Most reports cite data from specific popu-

TABLE 1. MEDICAL SIGNS AND SYMPTOMS OF INCEST

Vaginal discharge
Abdominal pain
Seizure disorder
Enuresis and encopresis
Venereal disease
Pregnancy
Urinary tract symptoms
Headache
Conversion symptoms
Vaginismus
Insomnia
Anorexia
Suicide

TABLE 2. BEHAVIOR PROBLEMS IN INCEST VICTIMS

Depression
Poor grades
Withdrawal from extracurricular activities and/or peers
Running away
Drug abuse
Promiscuity and/or prostitution
Multiple somatization

lations (ie, psychiatric wards, court records, runaways) that are not necessarily representative of the general population. The Children's Bureau of the American Humane Society estimates the incidence of incest in the general population of the United States to be 100,000 to 1,000,000 pairs of people per year.[2] Most incest is not reported. One investigator estimates that about 90 percent of incest cases fall into this category.[3] Cases that are reported may be skewed toward lower socioeconomic populations because they are more likely to come to the attention of the courts or social service agencies. In 1955, Weinberg reported a disproportionately high incidence of incest among blacks and European immigrants.[4] However, these data were obtained from court records in Illinois and are thus subject to socioeconomic bias. Meiselman's controlled studies from the psychotherapy clinics at UCLA showed a slightly lower relative incidence among blacks.[5] Most investigators agree that incest occurs without regard to race or class.

Brother-sister incest is considered the most prevalent form of incest. Not much attention is paid to this phenomenon when it occurs in a family free of other pathologic conditions because it is felt to be relatively innocuous. On the other hand, sexual misuse between father and daughter is often very traumatic. In this category are included stepfather-daughter and male parent surrogate-daughter. These relationships are usually accompanied by other social and family problems. Father-son, mother-son, and mother-daughter incest is relatively rare and is usually associated with major psychopathology in one or both participants. This paper will concentrate on father-daughter incest because of its potential traumatic outcome and its frequency.

RECOGNITION

The medical (as opposed to behavioral) recognition of incest is difficult in the older adolescent and adult because many of the signs and symptoms of incest would not arouse suspicion in this age group. However, if these signs and symptoms are found in younger patients, the family physician should give strong consideration to incest in the differential diagnosis. Table 1 lists presenting signs and symptoms commonly associated with incest. The family physician should not be misled by the fact that these are everyday complaints. A high index of suspicion will avoid missed cases. The medical aspects of evaluating incest have been well described elsewhere.[6-8]

Table 2 provides a list of behavioral problems that have been identified in incest victims. When evaluating a patient for suspected incest, it is essential to consider her behavioral problems within the context of her family life. Evaluating the patient in isolation may cause one to miss important family dynamics that are essential to the diagnosis. When incest is suspected or a family or family member has multiple office visits for minor or recurring problems and it becomes apparent that there is a family "secret," then a family study is recommended. A family study is a method for collecting, recording, and storing family data,[9] based on the work of Murray Bowen, who developed a concept of family systems theory while working with the families of schizophrenics.[10]

Table 3 summarizes the information to be in-

TABLE 3. INFORMATION RECORDED ON GENOGRAM

Dates—births, marriages, divorces, death, etc.
Names
Family medical history
Geographic changes
Occupations
Education
Ethnicity
Nodal (Stress-producing) events
Toxic issues
Religion
Income status
Social life
Description and quality of intrafamily relationships

cluded in a family study. With as many family members present as possible, data are graphically recorded with a large pad on an easel in the form of a "family tree." This method often stimulates a very productive session because families become animated and eager as they see themselves depicted on the page. The resulting information is usually qualitatively and quantitatively superior to what is gained from a conventional interview.

Previous history of incest in the family is a major risk factor.[11] In Meiselman's controlled psychotherapy sample "nearly 30 percent of the patients had either been sexually involved with more than one family member themselves or knew of other incestuous affairs within their families."[5] Raphling et al reported a family in which 11 members were involved in incest over three generations.[12] While this example is not typical of the usual situation with an incestuous family, it does serve to illustrate the utility of recording explicit family history and dynamics.

Herman and Hirschman[13] demonstrated patterns compatible with incestous or incest-prone families. These investigators compared 40 women who had incestuous relationships with their fathers with 20 women whose fathers were seductive, but not overtly incestuous. Fathers in the incestuous group were likely to use force and presided over the family with intimidation. Mothers were often ill or disabled to the point where there were extended absences from the home. Alcoholism, depression, and psychosis were reported. The mothers had more pregnancies and children. Also, they and siblings of the victims were more likely to be battered. The daughter had to assume the mother's traditional duties as early as age eight or nine and became more likely to run away, attempt suicide, or get pregnant during adolescence.

Other hints of incest may come to light in the family study. Sexual estrangement of the parents can be compounded by the mother's isolation from the whole family. Her distancing from the family creates a situation where the father and daughter get closer without anyone to protect the daughter's best interests. Some mothers may be so averse to sexual relations with their husband that they will put the daughter in bed between them. Most are not that flagrant, but they participate in the affair on a more subtle level. Her behavior may be the result of a poor relationship with her mother or having been sexually abused as a child.

The father's susceptibility to incest is increased by stress, depression, alcohol, and sexual isolation. He is often introverted and shy with few interests outside of the home. Usually he is unable or unwilling to seek sexual gratification outside the home. He may be very devout and use religion to rationalize the incest. He most likely suffered from poor parenting as a child.

The daughter-victim will often appear to be very mature and responsible. She will take charge of the household, organize activities for her siblings, and may even be a mother to her mother. On the other hand, her mother's isolation and lack of nurturance can cause her to suffer from low self-esteem and a poor self-image, making her hungry for attention. Inwardly, she is confused and depressed. She may be seclusive and withdrawn from family and peers. These young ladies can learn at an early age how to be seductive to gain attention and affection. Being "daddy's favorite" and sharing their "secret" in an otherwise unhappy household can be a boost to a love-starved child. In turn, she may feel a special responsibility for her father and family and may notice that family tension decreases when her father is sexually satisfied. As adolescents, these young ladies are more likely to adopt maladaptive behaviors.

Her siblings may be glad to have her handle the tension in the family. Conversely, they can be jealous of the favored attention she receives. They have been known to imitate their sister's pseudo-mature ways, leaving them open for molesting from other adults.[14] The next youngest daughter will be in line for incestuous overtures, but is more

likely to refuse. She does not feel the same responsibility as her older sister. She has been called the most "intact" member of the family.[15]

All of the characteristics noted will not be present in every family. If the history and family study suggest the possibility of incest, then direct but tactful individual questioning of the daughter and other family members is necessary. Often suspicions will not be confirmed unless sufficient rapport and trust have been achieved.

PROGNOSIS

The timing of intervention in relation to the onset of the incest can have some effect on the outcome. The probability of lasting negative effects to the victim is reduced if the incest is stopped early. In addition, early intervention may protect younger siblings by preventing their future involvement in an incestuous relationship.

If disclosure is made when the child tells (and is believed by) her mother, or some other significant person, after the first attempt or consummation, the likelihood of recovery is good. In this instance family roles are usually still intact and support systems, ie, family, social services, physicians, and the courts, have an opportunity to provide protection and nurturance to the victim and treatment for the father. Disclosure occurring after the incestuous relationship has existed for some time can result from the daughter's growing maturity and social awareness. After several years, she may want to stop the relationship so she can pursue interests that are compatible with her peer group.

Occasionally a mother who has consciously or unconsciously known of the incestuous relationship between her husband and daughter for some time will report it as an act of revenge against her husband, who offended her in some way totally unrelated to the incest. The relationship may be exposed totally by accident. Prognosis in these situations is variable and depends on the victim's resiliency and the degree of familial pathology. When disclosure is made after the relationship has ceased, there are two possible outcomes. The first is outside the province of medicine because some women claim no negative aftereffects.[16] Others in this category will have marital, sexual, health, or psychiatric problems. They will carry the burden of their past with them unless the emotional trauma and conflicts can be resolved through treatment.

TREATMENT

Incest should not be regarded as pathology in isolation. The conditions that allow incest to evolve are part and parcel of a familial milieu that is out of balance. Treatment involves a team approach of family therapy, individual therapy, and the courts. The family physician can act as a therapeutic manager for the family by coordinating activities between social workers, psychologists, schools, and representatives of the court.

The family physician is cautioned to be aware of his or her personal feelings before defining the immediacy of the situation. The formulation of short-term goals should be in the best interests of the daughter-victim and family, rather than provide a sense of relief to the physician.[17] This phenomenon has brought concern about overtreatment (or self-treatment) because the aftereffects of public exposure may aggravate the problem.[18,19] Some successful treatment programs, however, use the courts as a coercive agent to mandate treatment.[20,21] In those jurisdictions in which the father is jailed or the daughter is placed in "protective custody" upon notification of the courts, statute revision is necessary to allow flexibility and cooperation with more optimal treatment protocols. Ideally, the adept family physician should be able to pick up cues on the potential of incest prior to consummation. Preventive intervention would protect the family from itself and allow a smoother transition to homeostasis. Other forms of prevention include programs that promote women's mental health needs, such as alcoholism programs and battered women's shelters.

The magnitude of the incest taboo is increased by the call of some authors for controlled studies evaluating treatment modalities. This would be virtually impossible because of the difficulty of getting representative populations and ethical questions. Management should be based upon an assessment of the individual needs of the affected family. Improvements in management will come with early recognition, continuing medical education of the primary physician, an open climate for discussion, and cooperation between the courts, social agencies, and physicians. Further research and perhaps mass computerization of family stud-

ies may in the future help identify subsets of incest that will respond to different treatment modalities.

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